GREGG CHIROPRACTIC LIFE CENTERS, P.C.

1647 Inkster Road ~ Garden City, MI 48135 ~ 734-525-8422
215 E. Big Beaver Rd, Ste. 400 ~Troy, MI 48083 ~248-435-0925

DATE: _____

PATIENT INFORMATION

Name: _____ ☐ **M** ☐ **F** **Birthdate:** ____/____/____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Social Security Number: _____-_____-_____ ☐ **single** ☐ **married** ☐ **separated** ☐ **divorced** ☐ **widowed**

Home #: _____ **Cell #:** _____ **Email:** _____

Preferred contact method: ☐ **Home** ☐ **Work** ☐ **Cell**

Are you interested in receiving ☐ **Text or** ☐ **Email appointment reminders?**

Spouse's Name: _____ **Do you have children?** ☐ **Y** ☐ **N** **How Many?** _____

HOW DID YOU HEAR ABOUT US? ☐ **Referral** _____ ☐ **Radio** ☐ **Walk-In** ☐ **Website** ☐ **Insurance** ☐ **Other** _____

ETHNICITY: ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino** / **DOMINANCE:** ☐ **Right handed** ☐ **Left Handed** ☐ **Ambidextrous**

RACE: ☐ **American Indian** ☐ **Asian** ☐ **Black, African American** ☐ **Native Hawaiian** ☐ **White** ☐ **Other** ☐ **Decline**

FEMALES: **Is there a possibility that you may be pregnant?** ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ **Relationship:** _____ **Phone:** _____

INSURANCE INFORMATION

PRIMARY
Insurance Company: _____ **Contract No.** _____ **Group No.** _____
SECONDARY
Insurance Company: _____ **Contract No.** _____ **Group No.** _____

OCCUPATION

☐ **Not Employed** ☐ **Part-Time Student** ☐ **Full-Time Student** ☐ **Retired** ☐ **Employed**

Employer Name: _____ **Employer Phone No.** _____

Occupation: _____ **My job duties include:** ☐ **Sitting** ☐ **Standing** ☐ **Light labor** ☐ **Heavy labor**

Primary Care Physician Information

Practice Name: _____ **Doctor Seen:** _____ **Office Phone #:** _____

Address: _____ **City:** _____ **ST:** _____ **ZIP:** _____

PRIMARY COMPLAINT: _____Does the pain travel anywhere else?_____

Do you know what has caused the problem? ☐ NO ☐ Yes (please explain) _____

Are your complaints related to an accident? ☐ **yes** ☐ **no** **If yes,** ☐ **work related** ☐ **auto** ☐ **other**_____

Onset of pain? Have had symptoms for the past _____ ☐ Days ☐ Weeks ☐ Months ☐ Years

Do you notice the pain during a certain time of the day? ☐ Morning ☐ Afternoon ☐ Evening

Frequency of the pain? _____ times per ☐ Day ☐ Week ☐ Month ☐ Year

Duration of the pain? Lasting _____ ☐ Minutes ☐ Hours ~ **Intensity:** ☐ Minimal ☐ Slight ☐ Moderate ☐ Severe

Rate your pain: *0 being no pain at all and 10 being the worst pain imaginable*

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Describe your pain:

☐ aching ☐ burning ☐ cramping ☐ deep ☐ dull ☐ numb ☐ radiating ☐ sharp ☐ shooting ☐ sore ☐ stabbing ☐ stiff ☐ swelling ☐ tight ☐ tingling ☐ throbbing

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What makes the problem worse?

☐ nothing ☐ most movements ☐ bending ☐ carrying things ☐ coughing ☐ driving ☐ eating ☐ exercise ☐ going down stairs ☐ standing ☐ sitting ☐ pushing ☐ pulling ☐ jogging ☐ twisting ☐ turning ☐ working ☐ running

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What makes the problem better?

☐ nothing ☐ anti-inflammatories ☐ bracing ☐ chiropractic care ☐ elevation ☐ exercise ☐ heat ☐ ice ☐ massage ☐ movement ☐ pain killers ☐ rest ☐ stretching ☐ walking ☐ wraps

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Does your pain interfere with:

☐ bathing ☐ caring for children ☐ cleaning ☐ climbing stairs ☐ cooking ☐ doing laundry ☐ dressing ☐ driving ☐ eating ☐ exercising ☐ grooming ☐ housework ☐ laying down ☐ lifting ☐ oral care ☐ shopping ☐ sitting ☐ sleeping ☐ social/recreational activities ☐ standing ☐ stretching ☐ walking ☐ working ☐ yard work

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Please check off any other problems you may have:

Current	Past		Current	Past		Current	Past	
☐	☐	**Neck pain**	☐	☐	**Mid back pain**	☐	☐	**Feet Numbness ☐L / ☐R**
☐	☐	**Neck Stiffness**	☐	☐	**Mid back stiffness**	☐	☐	**Constipation**
☐	☐	**Headaches**	☐	☐	**Shoulder pain ☐L / ☐R**	☐	☐	**Poor circulation**
☐	☐	**Dizziness**	☐	☐	**Shoulder tightness ☐L / ☐R**	☐	☐	**High blood pressure**
☐	☐	**Head feels heavy**	☐	☐	**Rib pain ☐L / ☐R**	☐	☐	**Asthma**
☐	☐	**Twitching of face**	☐	☐	**Pain in side ☐L / ☐R**	☐	☐	**Loss of balance**
☐	☐	**Grating in neck**	☐	☐	**Chest Pain ☐L / ☐R**	☐	☐	**Loss of taste**
☐	☐	**Muscle spasms in neck**	☐	☐	**Low back pain**	☐	☐	**Fatigue**
☐	☐	**Arm pain ☐L / ☐R**	☐	☐	**Low back stiffness**	☐	☐	**Nervousness**
☐	☐	**Arm Numbness ☐L / ☐R**	☐	☐	**Hip pain ☐L / ☐R**	☐	☐	**Sleeping trouble**
☐	☐	**Wrist pain ☐L / ☐R**	☐	☐	**Leg pain ☐L / ☐R**	☐	☐	**Arthritis**
☐	☐	**Hand Numbness ☐L / ☐R**	☐	☐	**Leg numbness ☐L / ☐R**	☐	☐	**Painful joints**
☐	☐	**Cold Hands ☐L / ☐R**	☐	☐	**Knee pain ☐L / ☐R**	☐	☐	**Swollen joints**
☐	☐	**Pain in ears ☐L / ☐R**	☐	☐	**Pain in feet ☐L / ☐R**	☐	☐	**Menstrual irregularity**

Energy level: ☐good ☐insufficient ☐erratic
Low (time of day)_____ ☐High (time of day) _____

Sleep: ☐trouble falling asleep ☐trouble staying asleep ☐restful ☐other _____

Stress: ☐None ☐low ☐moderate ☐severe what causes stress? _____

Have you had unexpected weight loss in the last 6 months? ☐no ☐yes if yes, how much?_____

MUSCULOSKELETAL: Please check ALL that apply ☐ None

☐Arm/hand pain ☐ back pain ☐feet/leg pain ☐hip ☐knee ☐lower back pain ☐mid back pain ☐upper back pain

☐ muscle or joint pain ☐neck pain ☐redness of joints ☐shoulder(s) pain ☐stiffness ☐swelling of joints

CARDIOVASCULAR/RESPIRATORY: ☐ None

☐chest pain, pressure or discomfort ☐cold hands/feet ☐coughing up blood (hemoptysis) ☐coughing up phlegm

☐difficulty breathing ☐dizziness/lightheaded ☐fainting ☐irregular heartbeat ☐palpitations ☐shortness of breath

☐sudden awakening w/ shortness of breath (paroxysmal nocturnal dyspnea) ☐swelling ☐ chest tightness

☐wheezing ☐other _____

HEAD/NECK: ☐None

☐dizziness ☐facial pain ☐grinding teeth ☐headache ☐head injury ☐hoarseness ☐jaw clicks ☐lumps

☐migraines ☐pain ☐sore throat ☐stiffness ☐swollen glands ☐tooth problems ☐trouble swallowing

☐other_____

EYES: ☐None

☐blurred vision ☐burning ☐cataracts ☐double vision ☐dryness ☐flashing lights ☐glasses/contacts ☐glaucoma

☐itching ☐pain ☐redness ☐specks ☐vision problems ☐other_____

EARS: ☐None

☐Buzzing in ears ☐Decreased hearing ☐drainage ☐earache ☐ear infections ☐poor balance ☐poor hearing

☐ringing in ears ☐other_____

NOSE: ☐None

☐Allergies ☐blocked sinuses ☐discharge ☐excessive mucus ☐hay fever ☐itching ☐nose bleeds

☐sinus pressure/pain ☐stuffiness/blockage ☐other_____

THROAT/MOUTH: ☐None

☐bleeding ☐blue lips ☐braces ☐dentures ☐difficulty swallowing ☐dry mouth ☐hoarseness ☐mouth pain

☐non-healing sores ☐redness ☐sore throat ☐sores on lips or tongue ☐swelling ☐thrush ☐tooth pain

☐other _____

URINARY: ☐None

☐blood in urine ☐burning or pain ☐difficulty urinating ☐frequent urinary tract infections ☐frequent urination

☐incontinence ☐kidney infections ☐kidney stones ☐unable to hold urine (incontinence) ☐up at night to urinate

☐urgency ☐water retention ☐other_____

GASTROINTESTINAL: ☐None

☐change in appetite ☐change in bowel habits ☐constipation ☐diarrhea ☐heartburn ☐nausea ☐rectal bleeding

☐swallowing difficulties ☐yellow eyes or skin (jaundice) ☐other _____

ENDOCRINE: ☐None

☐change in appetite ☐cold intolerance ☐constipation ☐diarrhea ☐dry skin ☐excessive thirst

☐frequent urination ☐heat intolerance ☐sweating ☐other_____

VASCULAR/HEMATOLOGIC: ☐None

☐calf pain with walking (claudication) ☐cold hands and feet ☐ease of bleeding ☐ease of bruising ☐leg cramping

NEUROLOGIC: ☐None

☐dizziness ☐easily angered/irritated ☐fainting ☐frequent crying ☐memory confusion ☐nervousness ☐neuralgia

☐numbness ☐poor concentration ☐seizures ☐suicidal thoughts ☐tingling ☐tremors ☐weakness

☐worry/anxiety ☐other_____

PSYCHIATRIC: ☐None

☐anxiety ☐depression ☐memory loss ☐nervousness ☐stress ☐other _____

TRAUMAS

Have you ever had any injuries, accidents, or falls *(even if you think you were not hurt at the time)*? ☐ No ☐ Yes, if yes please indicate below.

When? Month_____ Year_____ Type of injury: _____

When? Month_____ Year_____ Type of injury: _____

When? Month_____ Year_____ Type of injury: _____

SURGERIES

Surgery	Month/Year	Surgery	Month/Year
_____	_____	_____	_____
_____	_____	_____	_____

Please indicate any treatments/testing you have received and where

☐ **Chiropractic** **Where:** _____ **Phone No.** _____

☐ **Physical Therapy** **Where:** _____ **Phone No.** _____

☐ **Surgery** **Where:** _____ **Phone No.** _____

☐ **MRI** **Where:** _____ **Phone No.** _____

☐ **CT Scan** **Where:** _____ **Phone No.** _____

☐ **Medical Doctor** **Where:** _____ **Phone No.** _____

☐ **Other _____** **Where:** _____ **Phone No.** _____

Have you had any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV	☐	☐	Anemia	☐	☐	Anxiety
☐	☐	Bleeding disorders	☐	☐	Cancer	☐	☐	Chemical dependency
☐	☐	Depression	☐	☐	Diabetes	☐	☐	Epilepsy/Siezures
☐	☐	Fractures	☐	☐	Heart disease	☐	☐	Hepatitis
☐	☐	Hernia	☐	☐	Herniated disc	☐	☐	High cholesterol
☐	☐	Multiple sclerosis	☐	☐	Osteoporosis	☐	☐	Pacemaker
☐	☐	Parkinson's disease	☐	☐	Polio	☐	☐	Prostate problems
☐	☐	Prosthesis	☐	☐	Psychiatric care	☐	☐	Stroke
☐	☐	Suicide attempt	☐	☐	Thyroid problems	☐	☐	Tumors
☐	☐	Ulcers	☐	☐	Other _____			

MEDICATIONS, VITAMINS, AND SUPPLEMENTS

Are you currently taking any form of medication? ☐ **NO** ☐ **Yes (please list below)**

Medication Name	Dosage (ex. Mg)	Vitamin/Supplement	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES & MEDICATION ALLERGIES

Are you allergic to anything? ☐ **No** ☐ **Yes** **(if "YES" please list any and all allergies)**

ALLERGIC TO:_____**REACTION:** ☐ anaphylaxis ☐ difficulty breathing ☐ nausea ☐ rash ☐ swelling ☐ hives ☐ vomiting ☐ other

ALLERGIC TO:_____**REACTION:** ☐ anaphylaxis ☐ difficulty breathing ☐ nausea ☐ rash ☐ swelling ☐ hives ☐ vomiting ☐ other

ALLERGIC TO:_____**REACTION:** ☐ anaphylaxis ☐ difficulty breathing ☐ nausea ☐ rash ☐ swelling ☐ hives ☐ vomiting ☐ other

DAILY HABITS

DO YOU SMOKE? ☐Never smoked ☐former smoker ☐current every day smoker ☐current some day smoker

If yes, how many packs per day? _____ How many years?_____

Daily caffeinated beverages: ☐unknown ☐none ☐1 to 3 ☐ 4 to 6 ☐ 7 to 10 ☐ 11 to 15 ☐ 16 to 20 ☐ 21 to 25 ☐ Over 25

Weekly Alcoholic Drinks: ☐unknown ☐none ☐1 to 3 ☐ 4 to 6 ☐ 7 to 10 ☐ 11 to 15 ☐ 16 to 20 ☐ 21 to 25 ☐ Over 25

Do you exercise regularly? ☐no ☐light ☐moderate ☐heavy

ILLNESSES:

☐ AIDS/HIV	☐chronic fatigue	☐heart disease	☐miscarriage	☐seizures
☐anemia	☐depression	☐hepatitis	☐multiple sclerosis	☐stroke
☐arthritis	☐ diabetes	☐hernia	☐osteoporosis	☐suicide attempt
☐asthma	☐emphysema	☐herniated disc	☐pacemaker	☐thyroid problems
☐bleeding disorders	☐epilepsy	☐high blood pressure	☐parkinson's disease	☐tuberculosis
☐breast lump	☐fibromyalgia	☐high cholesterol	☐pinched nerve	☐tumors/growths
☐bronchitis	☐fractures	☐immune deficiency	☐prostate problems	☐ulcers
☐cancer	☐gallstones	☐kidney disease	☐prosthesis	☐vaginal infections
☐chemical dependency	☐glaucoma	☐liver disease	☐psychiatric disorder	☐venereal disease
☐chicken pox	☐gout	☐migraine headaches	☐rheumatoid arthritis	☐whooping cough

☐other_____

SUBJECTIVE FINDINGS *PAIN CLASSIFICATION*

CERVICAL:	☐ Mild	☐ Moderate	☐ Severe	☐ Sharp	☐ Dull	☐ Aching	☐ Intermittent	☐ Constant
THORACIC	☐ Mild	☐ Moderate	☐ Severe	☐ Sharp	☐ Dull	☐ Aching	☐ Intermittent	☐ Constant
LUMBAR:	☐ Mild	☐ Moderate	☐ Severe	☐ Sharp	☐ Dull	☐ Aching	☐ Intermittent	☐ Constant
PELVIC:	☐ Mild	☐ Moderate	☐ Severe	☐ Sharp	☐ Dull	☐ Aching	☐ Intermittent	☐ Constant

OBJECTIVE FINDINGS

CERVICAL: Muscle Spasms ☐ L ☐ R ☐ Fixations _____

THORACIC: Muscle Spasms ☐ L ☐ R ☐ Fixations _____

LUMBAR: Muscle Spasms ☐ L ☐ R ☐ Fixations _____

PELVIS: Muscle Spasms ☐ L ☐ R ☐ Fixations _____

RANGE OF MOTION	CERVICAL				LUMBAR			
	+	-	RESULT	NORM	+	-	RESULT	NORM
Flexion				45				90
Extension				45				30
Lateral Flexion				45R				30R
Lateral Flexion				45L				30L
Rotation				80R				30R
Rotation				80L				30L

NEUROLOGICAL

Absent	Hypoactive	Normal	Hyperactive	Hyperactive w/TC	Hyperactive w/SC
0	1+	2+	3+	4+	5+

C5	Biceps	L _____ R _____
C6	Brachioradialis	L _____ R _____
C7	Triceps	L _____ R _____
L2-4	Patellar	L _____ R _____
SI	Achilles	L _____ R _____

Babinski Reflex ☐ POS ☐ NEG

AREAS OF TENDERNESS

CERVICAL: ☐ L ☐ R _____

DORSAL: ☐ L ☐ R _____

LUMBAR: ☐ L ☐ R _____

PELVIC: ☐ L ☐ R _____

POSTURAL DISTORTION

HEAD TILT: ☐ L ☐ R

Shoulder High On: ☐ L ☐ R

Ilium High On: ☐ L ☐ R

Forward Head Carriage: ☐ Y ☐ N

ORTHOPEDIC TESTS

	L	R	N
Foraminal Compression	☐	☐	☐
Shoulder Depression	☐	☐	☐
Cervical Syndrome	☐	☐	☐
Supine Leg Check	☐	☐	☐
Soto-Hall	☐	☐	☐
Minor's Sign	☐	☐	☐
Bechterew's Test	☐	☐	☐
Kemp's	☐	☐	☐
Lindner's	☐	☐	☐
Braggard's	☐	☐	☐
Bilateral Leg lower/raise	☐	☐	☐
Heel and Toe Test	☐	☐	☐
Nachla's Test	☐	☐	☐
Ely's Test	☐	☐	☐
Hibbs	☐	☐	☐
Fabere-Patrick	☐	☐	☐
Gaenslen's Test	☐	☐	☐
Lasegue's _____ L _____R	☐	☐	☐
Apley's Scratch Test (shoulder)	☐	☐	☐
Apley's Aprehension (knee)	☐	☐	☐

X-RAY REPORT & SPINAL ANALYSIS

At	☐	1L	☐
Ax	☐	2	☐
3	☐	3	☐
4	☐	4	☐
5	☐	5	☐
6	☐		
7	☐	L. Ilium	
1D	☐	PI	☐
2	☐	As	☐
3	☐	In	☐
4	☐	Ex	☐
5	☐		
6	☐	R. Ilium	
7	☐		
8	☐	PI	☐
9	☐	As	☐
10	☐	In	☐
11	☐	Ex	☐
12	☐		

Osteophytic Changes C ☐ T ☐ L ☐

Degeneration C ☐ T ☐ L ☐

Loss of Lordotic Curve C ☐ L ☐

Spina Bifida

Sacralization L ☐ R ☐

Lumbarization L ☐ R ☐

Neuroforaminal Stenosis C ☐ L ☐

Scoliosis (Lateral Curve)

Cervical ☐ L ☐ R

Thoracic ☐ L ☐ R

Lumbar ☐ L ☐ R

Spondylolisthesis Grade _____

Retrolisthesis Grade _____

Compression Fracture

Osteoporosis

☐ mild ☐ moderate ☐ severe

Spinal Fusion

☐ congenital ☐ surgical

Ht. _____ Wt _____ Blood Pressure _____ Ambulatory ☐ Yes ☐ No Antalgia ☐ Yes ☐ No

Subluxation	Connective Tissue	Nerve Tissue	Bio Mech.	Symptom

Special Instructions:

_____

_____

_____

_____

CORRECTIVE CARE PLAN

☐ Daily visits for _____ weeks

☐ 3 visits per week for _____ weeks

☐ 2 visits per week for _____ weeks

☐ 1 visit per week for _____ weeks

☐ 1 visit every 2 weeks ☐ 1 visit per month

M T W TH F SA SU

☐ Spinal Manipulation

☐ Traction

☐ Ice ☐ Heat

☐ Spinal Decompression

☐ Laser

☐ Massage

☐ Exercises

_____

Doctor Signature Date